Section 4000

4000 INDIVIDUALS IN MEDICAL INSTITUTIONS

4010 DEFINITIONS

I. "Institutionalization": A person is considered to be institutionalized when s/he is residing in a hospital or nursing home and is expected to remain for 30 consecutive days. A hospital is one that is primarily for the care and treatment of patients with disorders other than tuberculosis or mental disease. Individuals who die prior to the end of the 30 day period are considered to be in an institutionalized status.

A. Institutionalization triggers special income and asset limits that are effective on the 1st day of the month in which the 30 days of continuous institutionalization starts. For example, the individual enters a hospital or nursing home on March 20th and remains for at least 30 continuous days. Special income and asset limits are effective March 1st.

The special income and asset limits for institutionalization are as follows:

1. Residing in a hospital.

(a) Gross income of the individual must be equal to or less than the Categorically Needy Income Limit in Chart IV.

(b) Countable assets of the individual must be under $2,000. If there is a community spouse, the spousal share of assets is determined as defined in Section 4000.

2. Residing in a Nursing Home.

(a) Gross income of the individual must be less than the private rate for a semi-private room in the facility where the individual resides.

(b) Countable assets of the individual must be under $2,000. If there is a community spouse, the spousal share of assets is determined as defined in Section 4000.

3. In order to use these special income and asset limits, the individual must be medically in need of the hospital or nursing home level of care as determined by the Department of Human Services or it's designee.

B. If the individual in a hospital or nursing home is institutionalized for 30 continuous days covering a full calendar month there is a cost of care for the individual as determined in Section 4000.

4010 cont.

II. “Community Spouse”: A person who, according to state law, is married to an institutionalized spouse. An individual in a Boarding Home or a spouse at home receiving Home Based Waiver Services is considered residing in the community,

III. "Nursing Status": The Department has determined that an individual requires the services provided by a nursing facility. This determination may be made while awaiting placement in a hospital or in the community, or after entering one of the two types of nursing facilities:

A. NF 1, 2, or 3 (Intermediate Care Facility) including an ICF-MR.

B. NF 4, 5 SNF (Skilled Nursing Facility)

IV. "Spousal Allowance": The specialized treatment of income and assets for an individual who has a spouse living in the community and who is "awaiting placement" in a hospital or residing in a nursing facility or hospital and expected to remain for at least 30 consecutive days.

V. "Cost of Care": The amount of money certain individuals are responsible to pay to the medical facility each month for care.

4020 COVERABLE GROUP

Individuals applying for NF coverage must have a coverable group. Persons receiving Social Security, Railroad Retirement, SSI based on disability or blindness, or Medicare, automatically meet the disability/blind criteria in Sections 3130/3120.

4030 CLASSIFICATION

In order for Medicaid to pay for the cost of nursing care for an institutionalized individual, that person must be in medical need of that level of care. This decision is made by the Department of Human Services or it’s designee.

4030 cont.

A cost of care is given for the first full calendar month.

If an individual in a Nursing Facility does not meet the medical need criteria, that person may still be eligible for Medicaid coverage if the individual would be eligible if they were living in the community. Coverage is determined using the rules in Chapter 3000 or 6000 for an individual in the living arrangement, "living alone or with others". In this situation, Medicaid will not pay for nursing care costs that are coverable under the Medicaid rate nor can they be used toward meeting a deductible.

4040 AWAITING PLACEMENT FOR RESIDENTIAL CARE (DAP or APRC)

If an individual applies for Medicaid coverage of nursing care services in a nursing care facility and is denied because they have been determined to be not in need of that level of care, they may be eligible for coverage as APRC (Awaiting Placement for Residential Care). This coverage is for individuals converting from private pay including Medicare to Medicaid and found not in need of nursing facility level of care.

I. The following financial criteria must be met:

A. asset and all non-financial criteria are the same as for an individual residing in a Cost-Reimbursed Boarding Home (CRBH). See Section 3600.

B. countable income is determined using the same rules as for an individual residing in a CRBH;

C. the individual's countable income must be less than the amount in Chart III(h). A cost of care to be paid to the nursing facility is determined using the same rules as for an individual in a CRBH. SSI and State Supplement benefits are counted when determining the cost of care.

If countable income is equal to or over the amount in Chart III(h), the daily rate in Chart III(h) can be used as the cost incurred for medical expenses in determining a “spendown” (deductible).

II. The Bureau of Elder and Adult Services must establish that the individual meets non-financial criteria as identified in the Principles of Reimbursement for Boarding Homes on Cost Reimbursement.

III. Coverage under APRC ends when:

A. the provisions of Section 8110, "Principles of Reimbursement for Boarding Homes on Cost Reimbursement" are not met as determined by Bureau of Elder and Adult Services or it’s agent or

B. the individual becomes financially ineligible.

4040 cont.

IV. If countable income is equal to or less than the Community Medicaid income limit for the individual's coverable group, they can get Medicaid coverage in addition to help with the cost of room and board under APRC.

If countable income is over this amount, but less then the amount in Chart III (h), the individual is eligible for APRC only (not Medicaid).

4100 ASSETS

Individuals must use their assets to meet their needs. Specific types and amounts may be retained by the individual and community spouse to meet current and future needs.

All available assets are to be used in determining eligibility. Countable assets are defined in Section 3300. Asset limits are defined in Section 3370.

For individuals entering a nursing facility prior to 9/30/89, only the assets of the individual are considered in determining eligibility. Assets owned solely by the community spouse are not considered in the eligibility determination.

For individuals entering a nursing facility after 9/30/89 with a spouse living in the community, see Section 4130.

4110 COUPLES RESIDING IN A NURSING FACILITY

If the total assets of a couple in the same room in a nursing facility exceed the standard for a couple, one of the individuals may reapply for assistance. This results in one being an ineligible spouse. Beginning the first of the month after being denied, only the assets remaining in the name of the eligible spouse are considered when determining eligibility.

If the couple resides in different rooms in the same facility or in different facilities, then each is treated as an individual when determining the asset limit. Since there is no penalty for transfer of assets between spouses, they can decide who will retain the assets.

No spousal allowance of income or assets is determined since the ineligible spouse is not living in the community.

4120 TRANSFER OF ASSETS

When determining eligibility for nursing care services and home and community based services, the following applies to transfers by the individual or spouse. Transfers between spouses do not incur a penalty. The following rules are effective with transfers taking place as of 1/1/94. For transfers taking place prior to this date see Appendix 4-4. These are the rules that were in effect for applications received prior to 1/1/94. They are applied to transfers that took place prior to 1/1/94 once a transfer is found within the 36/60 month look back period described below. When determining eligibility for nursing care services and Home and Community Based Waiver services, the following applies to transfers by the individual or the individual's spouse.

Unless exempt, transfers by the individual are subject to a penalty if the transfer of assets takes place on or after 36 months prior to the month in which the individual is institutionalized and applies for Medicaid. This time period is referred to as the look back period. If the individual has had multiple periods of institutionalization and/or applications, the look back period starts with the first date on which the individual was institutionalized and applied for Medicaid.

In the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual, see Section 3330.24 for the applicable look back periods.

In establishing whether a transfer of assets has taken place, the term “individual” includes the individual him/herself as well as:

I. the individual’s spouse;

II. a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual’s spouse or with legal authority to act in place of or on behalf of the individual or the individual’s spouse.

DEFINITION OF ASSETS SUBJECT TO TRANSFER

For transfer purposes, an asset includes all income and resources of the individual and the individual's spouse. This includes any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual as defined above:

Transfers ONLY AFFECT nursing and waiver services, all other Medicaid services may still be covered.

To determine the effect that the transfer has on eligibility, several questions must be answered:

I. What was transferred?
II. Who was the transfer made to?
III. When was the transfer made?
IV. What did the individual or couple receive in exchange?
V. Why was the transfer made?

4120.01 EXEMPT TRANSFERS

The following may be transferred without penalty:

I. The home if it is transferred to:

A. a child who is under age 21 or who does or would meet SSI criteria or total and permanent disability or blindness.

B. a sibling who has an equity interest in the home and was residing in the home for at least one year prior to the individual going to the medical institution.

EXAMPLE:

A brother and sister have joint ownership of a home in which they both lived for the last 5 years prior to the brother going into a nursing facility. The brother may transfer his interest in the home to his sister without penalty.

A penalty would be established if:

1. the sister was not a joint owner or had no equity interest in the home, or

2. the sister had not lived in the home one year prior to the institutionalization of her brother.

C. a child over age 21 who does not meet the SSI criteria of blindness or disability if the child was residing in the home for at least two years prior to the individual's entering the medical institution and was providing care which enabled the institutionalized individual to live at home rather than a medical institution for this time.

D. a spouse.

II. Any asset transferred to the individual's child who does or would meet SSI criteria of total and permanent disability or blindness.

III. Assets which the owner intended to dispose of at fair market value or for other valuable consideration but without being at fault, the owner did not obtain full fair market value.

IV. Assets which the owner intended to dispose of at fair market value or for other valuable consideration but, without being at fault, the owner did not obtain full fair market value.

V. Assets transferred exclusively for a purpose other than to qualify for medical assistance either at the time of the transfer or at some future date. "Exclusively" means, transferred for that reason only and solely. It is not enough to prove that there was a reason to transfer in addition to gaining Medicaid eligibility. The reason for transferring must be exclusive of gaining Medicaid eligibility.

VI. Assets transferred for less than fair market value once all the assets have been returned to the individual. There is no penalty as of the month in which all the assets are returned to the individual. When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. A penalty remains in effect for the past time period during which the asset had been transferred.

VII. Assets transferred to (or for the sole benefit of) the community spouse.

VIII. Assets transferred 36 months prior to the month in which the individual is institutionalized and applies for medical assistance. When a transfer involved assets of a trust, the look back period is 36 or 60 months depending on the type of trust involved. See Section 3330.23.

IX. Assets transferred for Fair Market value.

A transfer is considered to be for the "sole benefit of" a spouse, blind or disabled child or disabled individual when no individual or entity except the spouse, blind or disabled child or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any other time in the future.

FAIR MARKET VALUE

A transfer for fair market value as defined in Section 3310 incurs no penalty. Fair market value may be received in cash by the individual.

Fair market value may be received by the individual in the form of payment of the individual's past medical expenses and debts if measurable and verified.

Fair market value may also be received in the form of past support for basic necessities if such support is measurable and verified. A reasonable value must be placed on the support provided and the specific time period must be substantiated for which it was given.

Past support for basic necessities does not include any items given as a gift or any services provided by relatives. Past support for basic necessities may include clothing, transportation or personal care provided by a relative only if this clothing, transportation or personal services were provided as part of a legally enforceable agreement whereby the individual would transfer the asset in payment for clothes, transportation or personal services.

Examples of transfer for fair market value:

I. An individual transfers ownership of a life insurance policy to a funeral home.

II. An individual's sister pays all household expenses while he waits for an insurance settlement of $5000. He verifies that his rent, utilities and food came to $4500. He may transfer the $4500 to his sister without penalty because these are basic necessities which are measurable and verifiable.

Examples of transfers for less than fair market value:

I. A couple sells their home to their son for $40,000. The assessed value is $70,000. A $30,000 transfer has occurred.

II. An individual has help from her daughter with shopping, cleaning and preparing meals. The daughter spends four to eight hours a week providing these services. When the individual enters a nursing facility she transfers $25,000 to her daughter to compensate for these services. Since these were not provided as part of a legally enforceable agreement to pay for these services, the transfer does result in a penalty.

III. A neighbor comes in for an hour a day to help a couple prepare meals and do laundry. Two years later the couple give the neighbor $50,000. Two months later they enter a nursing facility. Based on the average cost for homemaker services in the area a value of $10.00 per hour is placed on these services and $7280 of the transfer is allowed. The remaining $42,720 would be a transfer for less than fair market value.

DISPROVING THE PRESUMED TRANSFER

Any transfer taking place will be presumed to have been made for the purpose of becoming or remaining eligible for Medicaid, unless the individual furnishes clear and convincing evidence that the transaction was for some other purpose and that there was no intent at the time to apply for Medicaid within the foreseeable future. It is the Department's responsibility to demonstrate that a transfer took place and to establish the date of the transfer. It is the individual's responsibility to prove that the transfer took place for reasons other than to gain eligibility for Medicaid.

If the individual wants to disprove the presumption that the transfer was made to establish Medicaid eligibility, the burden of proof rests with the individual. The individual must demonstrate that the transfer was specifically and solely for some other purpose than to receive Medicaid. Statements and evidence to disprove the transfer must be contained in the individual's record.

The statement should cover, but not necessarily be limited to the individual's:

I. purpose for transferring the asset.

II. attempts to dispose of the asset for fair market value.

III. reasons for accepting less than the fair market value for the asset.

IV. plans for and ability to provide financial support after the transfer.

V. relationship, if any, to the persons to whom the asset was transferred.

VI. belief that the fair market value was received.

In addition to the individual having to prove that the transfer was made specifically and solely for a purpose other than to be Medicaid eligible, other factors to be considered include

I. a sudden onset of a disability or blindness after the asset was transferred.

II. the diagnosis of a previously undetected disabling condition after the transfer occurred.

III. unexpected loss of other assets following the transfer.

IV. unexpected loss of income after the transfer occurs.

V. court ordered transfers.

4120.02 ESTABLISHING DATE AND VALUE OF A TRANSFER

I. Assets other than bank accounts:

A transfer of assets occurs on the date when:

A. title (ownership) or legal interest to property has passed from the individual to another individual, for example

Sole ownership of a home valued at $100,000 is transferred to another. The value of the transfer is $100,000.

B. The individual establishes a joint ownership such as adding a name to stocks, bonds, real property,

In addition to legally transferring part ownership, the individual has taken action which reduced or eliminated their ownership or control of the remainder of the asset.

The date of the transfer is the date that the joint ownership was established.

The amount of the transfer is the total uncompensated value of the asset. For example:

In 10/95 the individual establishes joint ownership of their home valued at $100,000. The value of the transfer is $100,000. The date of the transfer is 10/95.

C. a document has been signed and delivered by the individual to another individual to transfer title at some future date. This concept does not include a will but does include a signed but unregistered deed,

D. the asset is converted from an accessible to an inaccessible asset. An example is when assets are placed in an irrevocable trust,

E. the individual takes action to refuse the receipt of assets.

F. unless otherwise exempt, when real property is sold and the individual holds a promissory note, a transfer of assets must be assessed as follows:

1. if the individual sold property for less than fair market value (see Section 4120.01, Fair Market Value), a transfer of assets has occurred amounting to the difference between the sale price (the presumed value of the note) and the value of the property, and

2. if the current value of the note is less than the presumed value, the difference between the two amounts is a transfer of assets.

The total amount of assets transferred due to (1) and (2) above incurs a penalty as of the date the real property is sold.

EXAMPLE:

In March, 1994, real property valued at $100,000 is sold and the individual holds a promissory note for $90,000. A transfer of $10,000 has occurred since the property was sold for less than fair market value.

The current value of the note is established at $60,000. An added amount of $30,000 is a transfer.

The total amount transferred is $40,000. ($10,000 from the sale of the real property and $30,000 from the current value of the note.) The date of the transfer is March, 1994.

II. Bank accounts:

With bank accounts, a transfer of funds in an account is determined to take place when:

A. funds, owned by the individual, are withdrawn by the other joint owner(s) from an account and used for other that the sole benefit of the individual.

or

B. another person's name is added to the individual's account, the money in the account is owned by the individual, and the intent of the individual in giving access is to convey ownership of those funds.

1. If the individual maintains that there was an intent to transfer funds in the bank account at the time a joint name was added, this intent must be documented.

   Documentation consists of a clearly written statement of intent to transfer the funds in the account to the joint owner. This statement must be:

   i. a notarized statement

   ii. signed by the individual at the time the account was made joint or within a reasonable period of time, usually 1 week but maybe longer due to circumstances beyond the control of the client.

   NOTE: Evidence of an intent to transfer the funds in the account at the time that the name was added to the account will be rebutted by evidence that the individual continued to use the funds.

EXAMPLE #1:

George adds his son Larry's name to a $50,000 bank account in 8/91. In 6/92 Larry withdraws $50,000 which he used to make renovations on his (Larry's) home. George is applying for nursing care services 9/92.

I. Whose money is the $50,000?

The money in the account is made up of deposits by George. This is George's money and there is a potential transfer.

II. What was George's intent of adding son's name?

If the intent was to convey ownership of the funds in the account, this must be documented with a notarized statement by George. In this situation, there is no statement from George. No transfer occurred when Larry's name was added as a joint owner..

III. The 6/92 withdrawal is then examined as a transfer. Since Larry used the $50,000 that was withdrawn for other than the sole benefit of George, a transfer has occurred. Unless the transfer is exempted (4120.01), the penalty is assessed for $50,000 as of 6/92.

EXAMPLE #2:

Sally adds her son's name (Sam) to her bank account in 12/88. At that time there was $70,000 in her account. At the time of adding her son's name to the account she signs a statement that she intends to transfer the funds in the account. Subsequently, Sally cashes a check for $10,000 from the account. Also during the transfer penalty period, Sam cashes a check for $20,000 from the joint account. At the time Sally applies for nursing care services in 9/92, there is $40,000 in the account.

I. The $20,000 spent by Sam was a transfer subject to penalty. This is because Sally's continued use of the funds in the account rebuts her written statement saying she intended to transfer the funds to her son at the earlier time. Since the funds were Sally's when Sam cashed the check for $20,000, this is a transfer subject to penalty.

II. The $40,000 remaining in the account is considered an available asset for Sally.

EXAMPLE #3:

Butch adds his nephew's name (Charles), to his (Butch's) solely owned bank account in 1/89. The $70,000 in the account was owned by Butch. There is documentation that Butch intended to transfer the funds in the account at that time. In 5/92, Butch sells a piece of his solely owned property for $20,000 and deposits this money in the joint account. Charles cashes a $20,000 check from the account in 6/92. The account totals $70,000 at the time Butch applies for nursing care services in 9/92.

I. The $20,000 withdrawn by Charles in 6/92 is considered to be part of the $70,000 that Butch intended to give his nephew in 1/89. Therefore, this $20,000 may not be subject to transfer penalty.

II. Of the remaining $70,000 in the account:

A. $20,000 is a countable asset for Butch since this $20,000 was deposited by him from his funds.

B. $50,000 is owned by Charles due to the 1/89 transfer of funds.

4120.03 ESTABLISHING A PENALTY

I. A period of ineligibility is imposed on the individual in a nursing care status if the individual or spouse disposes of an asset for less than Fair Market Value.

When a penalty is imposed, it is only the nursing care services that cannot be paid. The individual may be eligible for all other Medicaid services.

Once it has been determined that a transfer of assets has occurred for less than fair market value, the penalty period must be determined as follows:

A. Determine the date that each transfer occurred.

B. Determine the amount of the transfer.

C. Divide the amount of the transfer by the average monthly private rate at the time of application for a semiprivate room rate for a nursing facility (see Chart IVc).

This determines the number of months of ineligibility based on the transfer. Any remaining fraction is to be disregarded. The penalty period begins with the month in which the uncompensated transfer occurred. If a penalty is already in effect for that month, the penalty period will begin with the next non-penalty month.

If there has been more than one transfer in the same month, the penalty period is determined as follows:

1. Determining the total, cumulative, value of all transfers in the same month.

2. Divide the amount by the average monthly private rate at the time of application for a semi-private rate for a nursing facility (see Chart IVc).

This determines the number of months of ineligibility based on these transfers. Any remaining fraction is to be disregarded.

The penalty period begins with the month of the transfers. If a penalty is already in effect for that month, the penalty period will begin with the next non-penalty month.

EXAMPLES:

1. An individual transfers savings bonds to her daughter on 4/14. Based on the amount of the transfer she is ineligible for 7.3 months. The penalty starts on 4/1. Eligibility potentially begins 11-1.

2. An individual had a solely owned savings account with $60,000 in it. In October 1994 he transfers $60,000 to his daughter. He also owns stocks worth $40,000 which he transfers to his son in December 1994.

   10/94 $60,000 divided by $3619 = 16.5 months, potentially eligible 2/96

   12/94 $40,000 divided by $3619 = 11 months, potentially eligible 1/97

   The penalty on the 12/94 transfer does not start until 2/96. This is the first non-penalty month after the 12/94 transfer

   In this case the individual is potentially eligible as of 1/97.

3. An individual transfers savings bonds valued at $14,000 and stocks valued at $9,000. Both occur in April and are transfers for less than Fair Market Value.

   I. $23,000 is the total, cumulative value of these transfers in the same month.

   II. $23,000 divided by the average private pay rate results in a penalty of 6.3 months.

   III. the penalty begins in April and runs through 9/30. If a penalty was already in effect for April, it would start in the next non-penalty month.

B. At the time both spouses become institutionalized, have applied for and are otherwise eligible for Medicaid and there is a penalty period in effect for either spouse, the remaining penalty period can be divided between the spouses into any combination of full months. Whether there is a division of the penalty and, if so, how it will be divided, is a decision of the spouses.

   When, for some reason, one spouse is no longer subject to a penalty (for example, no longer lives in a nursing facility or dies), the remaining period applicable to both spouses must be served by the remaining spouse.

4130 ASSETS OF THE INSTITUTIONALIZED SPOUSE

When an institutionalized individual has a community spouse and

I. is expected to reside in a hospital or nursing facility for 30 days or more, or

II. is awaiting placement in a hospital

on or after September 30, 1989, assets must be looked at under special regulations.

Assets owned by the institutionalized spouse and community spouse are used when determining how much is considered available to the institutionalized spouse. All non-excluded assets that are owned

4130 cont.

by the couple (his, hers, theirs) on the first day of the month of application, are considered in the determination.

The community spouse is allowed to keep $89,280 (Chart IVd) of all countable assets owned by the couple. This is the Community Spouse Asset Allowance or protected share of assets. Any share of the couple's assets over this amount is considered to be available to the institutionalized spouse.

The Community Spouse Asset Allowance may be increased by a Fair Hearing (see Section 4130.01) if the Community Spouse's Asset Allowance is inadequate to raise that spouse's income to the Monthly Income Allowance. In this case, there shall be substituted an amount adequate to meet the Monthly Income Allowance.

The assets required to meet the Monthly Income Allowance shall be based on the Income Allowance set at the time of application.

4130.01 FAIR HEARING FOR COMMUNITY SPOUSE ASSET ALLOWANCE

Either the community spouse or institutionalized spouse may request a Fair Hearing if they have filed an application and they are dissatisfied with the determination of:

I. The community spouse protected share of countable assets.

II. The institutionalized individuals' share of assets.

The Department will make a determination of whether an amount greater than the Community Spouse Asset Allowance (Chart IV (d) (1)) is needed to raise the community spouse income to the Monthly Income Allowance.

If the individual agrees with the Department's decision, a Fair Hearing is requested using the Consent Decree in Appendix 4-2.

If the individual disagrees with the Department's determination, s/he may request a face-to-face Fair Hearing.

A determination is made as follows on whether assets in addition to the Asset Allowance (chart IV (d) (1)) are needed to meet the Income Allowance:

I. The Community Spouse Income Allowance is determined according to Section 4220

II. all community spouse gross income is subtracted from the Monthly Income Allowance. Gross income includes AFDC/SSI payments but does not include income generated by the couple's assets.

III. the Department will get two estimates of the price of a single premium lifetime annuity that will generate a payment equal to the difference between the spouse's gross income and the Monthly Income Allowance.

IV. the average of these two estimates shall be substituted for the amount of assets attributed to or protected for the community spouse when the Asset Allowance (chart IV (d) (1)) is less than the averaged cost of an annuity.

If the Asset Allowance is greater than the averaged cost of the annuity, there shall be no substitution for the cost of an annuity.

V. the spouse is not required to purchase this annuity.

4130.02 TRANSFER OF ASSETS TO THE COMMUNITY SPOUSE

Once the Community Spouse Asset Allowance has been established using the protected share and/or the Fair Hearing process, the couple has 12 months to transfer the protected assets to the sole ownership of the Community Spouse.

4130.03 NON-COOPERATION FROM THE COMMUNITY SPOUSE

If the community spouse does not make assets available to the institutionalized spouse, eligibility will not be denied if:

I. the institutionalized spouse has assigned to the State any rights to support from the community spouse. (See Section 1240.)

II. the institutionalized spouse is unable to execute an assignment of support due to physical or mental impairment. The State has the right to bring a support proceeding against a community spouse without an assignment under these conditions.

III. the State determines that denial of eligibility would cause an undue hardship. The consequences of being denied Medicaid for nursing care by itself does not constitute undue hardship.

4200 INCOME

Income for nursing status follows the definition in Section 3400 with the following exception:

I. If the income of the institutionalized spouse is being reduced due to previous overpayments by government agencies, the reduced payment amount is used.

4210 INCOME OWNERSHIP

The income ownership rules for purposes of this section supersede any State laws relating to community property or the division of marital property. The rules of ownership of income are as follows:

I. Income payments made solely in the name of one spouse are available only to that respective spouse.

II. When an income payment is made in the names of both spouses, one half is considered to be available to each, unless there is documentation to the contrary.

4210 cont.

III. If the payment of income is made in the names of the institutionalized spouse or the community spouse, or both, AND to another person or persons, the income is available to each spouse in proportion to the spouse's interest. When both spouse's names are on the payment and NO interest is specified, one half of the couple's interest is considered available to each spouse.

IV. Income from a trust is counted to the extent it is considered available (see Section 3330.23).

4220 COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE AND ALLOCATION DEFINITIONS

Minimum Income Standard - $1,452

Monthly Income Allowance - minimum income standard plus excess shelter costs.

Monthly Income Allocation - monthly income allowance minus community spouse income.

This amount is given to the community spouse by the institutionalized spouse. It is a deduction from the institutionalized spouse’s income in setting the cost of care.

At the time of application a determination of the minimum monthly income allowance for the community spouse is done.

The Minimum Income Standard of $1,452 when combined with the excess shelter costs is the Monthly Income Allowance which may not exceed $2,232. From this figure subtract the community spouse's gross income. The remainder is the Monthly Income Allocation. This allocation can only be increased by:

I. a court order specifying a higher amount, or

II. a fair hearing that establishes that the community spouse needs income above the Monthly Income Allowance due to exceptional financial circumstances.

If the gross monthly income of the community spouse is equal to or greater than the Monthly Income Allowance, no income allocation is made from the institutionalized spouse.

The Monthly Income Allocation is determined as follows:

I. Determine excess shelter costs:

Monthly shelter expenses for the community spouse's principal residence must also be considered when determining the Monthly Income Allowance.

4220 cont.

The shelter expenses used in this determination are limited to:

A. Rent or mortgage payment (principal and interest).

B. Taxes, homeowner's and renter's insurance payments.

C. Maintenance charges for condominiums or cooperatives.

D. Standard Utility Allowance used by the State under the Food Stamp Act of 1977. The utility standard will be reduced to the extent it is included in cooperative or condominium maintenance fees. See Appendix C for the computation of the utility standard.

If the countable monthly shelter expenses are less than or equal to $436 (30% of $1,452) then no shelter costs are given in the allowance.

If the countable monthly shelter expenses are greater than $436, any excess (above $436) is added to the allowance.

II. Combine the excess shelter with the Minimum Income Standard. This figure may not exceed $2,232. This is the Monthly Income Allowance.

III. Determine the gross monthly income of the community spouse including TANF/SSI payments. Include income actually generated from the Community Spouse Asset Allocation.

IV. Subtract gross monthly income from the Monthly Income Allowance figure in #2.

V. The balance is the Community Spouse Monthly Income Allocation. This income is allocated from the institutionalized spouse to the community spouse.

EXAMPLES:

A. Total Monthly Income Allowance must not exceed. $2,232

Excess Shelter	$498.00
Plus Minimum Income Standard	$1,452.00
Equals Monthly Income Allowance	$1,950.00
Minus Community Spouse Gross Income Allocation	500.00
	$1,450.00

4220 cont.

B. Total Monthly Income Allowance must not exceed $2,232.

Excess shelter	$ 798.00
Plus Minimum Income Standard	$1,452.00
Equals Monthly Income Allowance	$2,250.00
Maximum Income Allowance Allowed	$2,232.00
Minus Community Spouse gross income	700.00
Allocation	$1,532.00

4221 FAIR HEARING PROCESS FOR INCOME

Either the community spouse or institutionalized spouse may request a fair hearing if they have filed an application and they are dissatisfied with the determination of:

I. the Monthly Income Allowance;

II. the Monthly Income Allocation; and/or

III. the excess shelter allowance.

Either spouse may request a revision of the Monthly Income Allowance if they can establish a need, due to exceptional circumstances, which would create a financial hardship if more funds were not made available. This may occur either through the fair hearing process of a court order. The circumstances that caused the request are subject to Department review yearly to determine if continued receipt of the increased allowance is warranted.

If either spouse established that the community spouse needs income above the level otherwise provided by the Monthly Income Allowance, due to exceptional circumstances resulting in significant financial duress, there shall be supplemented to the Monthly Income Allowance an amount adequate to provide such additional income as is necessary. “Financial duress” is defined as the inability of the community spouse to meet current monthly household and/or medical expenses. “Such additional income as is necessary” is defined as the amount by which the community spouse’s actual and necessary household and/or medical expenses exceed the Monthly Income Allowance.

In order to establish exceptional circumstances resulting in significant financial duress, either spouse must establish that the community spouse has made use of resources and income to meet current monthly household and medical expenses, and that he or she has no other ability to meet those expenses. Exceptional circumstances will not be deemed to exist where application of the Monthly Income Allowance results in a change or inconvenience to the lifestyle of the community spouse if necessary monthly household and medical expenses can nevertheless be met.

4221 cont.

Once an application has been filed, either spouse may request a fair hearing to increase the community spouse's protected share of assets (see Section 4130) if the community spouse's monthly income does not meet the monthly income allowance. The additional assets are requested so that they will generate income and raise the community spouse's total available income to meet the income allowance. The additional allocation of assets to the community spouse may be revised as of the month of application. The asset allocation may not be revised prior to that month.

4230 DEPENDENT ALLOCATION

When an institutionalized individual has dependents living at home, an allocation may be allowed for their needs. The method of determining the allocation amount depends on whether there is a community spouse.

4230.01 DEPENDENT ALLOCATION WITH A COMMUNITY SPOUSE

For purposes of this section, a dependent is defined as a minor or dependent child, dependent parent(s), or dependent sibling(s) of the institutionalized individual or community spouse, who are residing with the community spouse. These dependents are individuals who may be claimed by the institutionalized or community spouse for tax purposes under Internal Revenue Code.

To determine the allocation:

1. Determine the gross monthly income of each dependent member including SSI and AFDC payments. Assets are considered only to the extent of interest or dividend income being generated.

2. Compare the gross income of each individual to the minimum income standard. (See Chart IV(d))

If the gross monthly income is equal to or greater than the standard, no allocation is made.

If the gross monthly income is less than the minimum income standard, subtract the income from the standard. Divide the remainder by three (3). The resulting figure is the allocation for each dependent.

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4230.02DEPENDENT ALLOCATION WITHOUT A COMMUNITY SPOUSE

For purposes of this section, a dependent is defined as a minor or dependent child, dependent parent(s), or dependent sibling(s) of the institutionalized spouse. These dependents are individuals who are or may be claimed by the institutionalized individual for tax purposes under the Internal Revenue Code.

To determine the allocation:

I. Determine the gross monthly income of all dependents living together including SSI and TANF payments. Assets are considered only to the extent of income being generated by the assets.

II. Compare the gross income of all dependents living together to the Full Need Standard in Chart II for the appropriate unit size. For example, 3 dependents would use the unit size of 3.

If gross monthly income is equal to or greater than the standard, no allocation is made.

If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.

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4300 ELIGIBILITY CRITERIA

In determining when eligibility begins and the type of coverage, consider these factors in the following order:

I. *Length of Stay:* If the individual was living in the community, but is expected to reside in a medical institution for 30 days or more, or is awaiting placement in the hospital, eligibility is established back to the first day of the month of admission. A determination of the spousal asset and income allowance is done in accordance with Sections 4130 and 4220.

If the stay is expected to be less than 30 days, only community eligibility is determined.

Individuals who die prior to the end of the 30 day period are considered to be in an institutionalized status for the entire month.

II. Countable Assets: If the countable assets for the individual (after determination of the spousal share) are less than $2000 on any day of the month for which eligibility is determined, the individual is potentially eligible as Categorically Needy.

III. Gross Income of the Individual: If the individual's gross income is less than $1302 they are potentially Categorically Needy. Individual's with gross income equal to or greater than $1302 are potentially Medically Needy.

Individuals who are changing from institutionalized status to community status must be given advance notice if coverage is ending.

4400 RECIPIENTS COST OF CARE

Institutionalized individuals are responsible for paying toward their cost of care for stays of a full calendar month. This payment goes to the facility where the individual was residing on the first day of the month. If the individual moves from one facility to another on the first day of the month, the facility to which the individual moves is paid the cost of care.

If the individual was in acute status for a full calendar month no classification will be done by consumer services. The individual may not owe anything to the hospital toward the room and board charges due to payments from Medicare and/or other insurance. A cost of care is still determined. The hospital will be responsible to collect any portion that is actually owed.

When, after third party payments, the balance for room and board is less than the individual's cost of care, the lesser amount will be collected by the facility. This includes the balance after Medicare and supplemental insurance payments for acute and skilled services and the balance after nursing home insurance for skilled and intermediate care.

There is no cost of care for SSI recipients in a medical institution if the Social Security Administration determines that the individual will be returning home within three months of entering the facility.

Individuals who receive SSI and whose total income is less than $60.00 (based on being in a nursing facility) have no cost of care.

The amount of an individual's cost of care may be adjusted, without advance notice. See Section 4530.

If the individual was institutionalized on the first of the month for which eligibility is being requested, the cost of care begins with that month.

If an individual was living in the community on the first of the month for which eligibility is being requested then the first cost of care is owed for the following month.

Individuals who are no longer in a nursing facility are to be refunded their cost of care for that month by the facility. If the individual is entering a Boarding Home or Adult Foster Home (see Section 3600) or if services will be provided under a waiver program (see Section 5000), a cost of care may be owed to the new provider based on the eligibility requirements for this new program.

4410 PARTIAL MONTH OF ELIGIBILITY

When an individual was living in the community on the first day of the month in which institutionalization occurs:

only the income of the individual is considered. Community spouse income is not considered except as identified in Section 4220;

the first cost of care is owed for the first full month of residing in the institution.

EXAMPLE:

An individual entered a nursing facility from their home (which may have been a Boarding Home) on August 2nd. They are Medicaid eligible as of August but the first cost of care is due for September.

For an individual who has paid privately for a portion of the month, determine the first day of classification based on how many days the individual has paid privately. Determine the cost of care based on whether the individual has been in a facility for a partial month ($0 cost of care) or a full month. Medicaid eligibility is determined for the full month.

EXAMPLE:

An individual has been paying privately for several months. His assets at the end of July were $2600. He chooses to pay $700 for August in order to bring his assets below the $2000 limit. The private rate for the facility is $85 per day. ($700 divided by $85 = 7.06 days).

Classification is requested as of August 8th. Cost of care is determined based on the individual's income for the month of August. Medicaid begins August 1st.

4500 BUDGETING

For any month that an individual is considered to be institutionalized a community spouse's income is never used, (including a partial month), except as identified in Section 4120.

To determine SLMB eligibility, see Section 3520 for an individual, Section 3530 for a couple in the same room and Section 3550 with an ineligible spouse in the same room. Aide and Attendance is not used in this process.

To determine QMB eligibility see Section 3520 for an individual, Section 3540 for a couple in the same room and Section 3550 for an individual with an ineligible spouse in the same room. Aid and Attendance is not used in this process.

For individuals who are categorically eligible, there is one budgeting process to follow. For those who are medically needy the budgeting process varies, depending on the individual's income.

4510 COST OF CARE FOR INDIVIDUALS WHO ARE CATEGORICALLY ELIGIBLE

An individual is categorically eligible for nursing care services if the gross income is below the categorical income limit (Chart IVa) and the countable assets, after the determination of any spousal share (see Section 4130), are below $2000 on any day of the month.

I. Determine the individual's gross monthly income.

II. An adjustment may be made if there are current federal, state or local income tax deductions from the institutionalized spouse's gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed. For example, last year $600 was due in income taxes. $80 per month is withheld for income tax. Only $50 per month can be allowed as a deduction.

NOTE: If an institutionalized spouse is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

III. Subtract the appropriate personal needs allowance. This is:

A. $40 per month, or

B. $130 for individuals receiving the reduced VA pension of $90 and for individuals in VA nursing facilities who receive a VA pension and are single with no dependents, or, they are the surviving spouse with no dependents, or.

C. up to the maximum dependent allowance (Chart IVb) for an individual who participates in a sheltered workshop. To determine the actual amount:

1. Subtract $40 from any unearned income.

2. Subtract any remainder of the $40 from earned income.

3. Subtract $50 from any remaining earnings.

4. Subtract one-half (1/2) of any remaining earnings.

The deductions of $40 and $50 and the one-half remainder figure are added together. This figure is the personal needs allowance. This figure may not exceed the maximum dependent allowance (Chart IVb).

4510 cont.

IV. Subtract the cost of

A. Medicare payments for the individual.

B. Health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in a Cost Reimbursed Boarding Home or nursing facility or covered by a Home Based Waiver.

* Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

NOTE: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

C. Certain Medical expenses:

(1) Paid or unpaid medical expenses incurred by a Medicaid covered individual, while residing in the facility, for necessary medical services as long as:

(a) the service is not covered in the per diem rate of the facility, (See Appendix 4-3).

(b) the service is not one the facility is expected to provide. The facility is expected to provide services contained in a written order or plan of care established by the individual's physician.

(2) Unpaid medical expenses incurred by the individual for necessary medical services. This includes payments on the unpaid balance of a loan taken out to pay for medical expenses incurred prior to Medicaid coverage provided (a) the proceeds of the loan were used to pay the medical bill. Only the amount of the loan actually used to pay the medical bill may be deducted and (b) only the principal (and not the interest) part of the unpaid balance may be used as a deduction.

(3) A medical expense will not be deducted from the cost of care if:

(a) the expense was covered by insurance (including Medicare)

(b) the expense was not covered due to a Medicaid penalty period of ineligibility

4510 cont.

(c) the Department has determined that the expense was not the responsibility of the individual because a medical assessment was not timely requested by the facility or because the facility did not timely and adequately assist the individual with filing a Medicaid application. This determination is made by the Bureau of Elder and Adult Services.

(d) the expense is the unpaid cost of care to a medical institution or a Waiver agency during periods of Medicaid coverage.

(e) the expense was for a Medicaid covered service and the individual was covered by Medicaid.

V. Subtract any spouse's and/or dependent's allocation. These figures are determined in Section 4220 and 4230.

VI. The remainder is the individual's cost of care.

EXAMPLE:

Eighty-four year old widow enters a hospital on 10/15. She is classified NF-AP on 12/2 and enters a Nursing Facility on 12/15. She has a gross Social Security check of $591.80, $100.00 in outstanding medical bills, and pays $48.91 monthly for medical insurance. In addition, she purchases 2 bottles of Tylenol at $1.49 each, and 2 hearing aide batteries at $5.00, monthly. All receipts have been provided and were dated 11/10.

These figures are based on amounts in effect 1/1/92:

October: $591.80 Gross Social Security is less than the Categorical income limit (Chart IVa).

Individual is eligible Categorically Needy nursing care with a $0 cost of care because she was not institutionalized for a full calendar month.

November:	$591.80	Gross Social Security
	- 40.00	Personal needs
	- 31.80	Medicare premium
	- 48.91	Other medical insurance
	-100.00	Outstanding medical bill
	=$371.09	Cost of care paid to the hospital

December:	$591.80	Gross Social Security
	- 40.00	Personal needs
	- 31.80	Medicare premium
	- 48.91	Other medical insurance
	- 10.00	Uncovered medical expenses (cannot allow for Tylenol, should be furnished by the facility)
	=$461.09	Cost of care paid to the hospital because she was in that facility on the 1st day of the month.
January:	$591.80	Gross Social Security
	- 40.00	Personal needs
	- 31.80	Medicare premium
	- 48.91	Other medical insurance
	=$471.09	Cost of care paid to the nursing facility. Uncovered medical expenses (batteries) must be verified each month.

EXAMPLE:

John enters the hospital on 2/17 from home. He moves to a nursing facility on 2/27. He is married and his wife Joan continues to live in their apartment. They have a $13,500 certificate of deposit from which they receive the interest monthly. The also have a non-interest bearing checking account with a balance of $738.29. John receives Social Security benefits of $729.80 and Joan receives $529.80. The rent is $550.00 monthly, including heat and lights.

These figures are based on amounts effective 1/1/92:

INCOME ALLOCATION

Joan's income		John's income
$529.80	Social Security	$729.80 Social Security
+ 65.26	interest income	
$595.06		
$550.00	Rent	
+ 24.00	Telephone	
$574.00		
-345.00	(30% of $1149)	
$229.00	Excess shelter	
+1149.00	Minimum income standard	
$1378.00	($1718 maximum)	
- 595.06	Joan's income	
$ 782.94	Income allocation to community spouse	

COST OF CARE

$729.80	John's income
- 40.00	personal needs
$689.80	
- 31.80	Medicare premium
$658.00	
-782.94	Income allocation to community spouse
0.00	Cost of care

4520 COST OF CARE FOR INDIVIDUALS WHO ARE MEDICALLY NEEDY DUE TO INCOME LESS THAN THE PRIVATE RATE

I. An individual is medically needy for nursing services if

the gross income is in excess of the categorical income limit (Chart IVa), but below the Medicaid rate for the facility.

the gross income is equal to or greater than the Medicaid rate, but below the private rate for the facility

The individual has a deductible to meet. This is always met by incurring the Medicaid rate or the private rate. Eligibility occurs on the first day of the month of eligibility for the 6 month period.

The following budgeting procedures are used.

II. To determine if the deductible is met:

A. Combine all gross unearned income.

B. Subtract the $20.00 Federal Disregard, where applicable.

The remainder is the net unearned income.

C. Combine all gross earned income.

D. Subtract any remainder of the $20.00 Federal Disregard not deducted for the unearned income.

E. Subtract the earned income disregard of $65.00.

F. Divide the remaining earned income by 2.

The remainder is the net earned income.

7. Combine the net earned and unearned income.

8. Subtract the Protected Income Level (PIL) for 1.

9. Multiply this figure by 6 to determine the total for the deductible period.

This is the individual's deductible.

4520 cont.

J. Subtract the cost of:

1. Medicare payments of the individual.

2. Health Insurance premiums incurred by the individual for the individual and /or the individual's spouse if the spouse is covered by Medicaid and is residing in a Cost Reimbursed Boarding Home or nursing facility or covered by a Home Based Waiver.

   * Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

   NOTE: Indemnity insurance premiums are not deducted. These are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

3. Outstanding medical bills incurred by the individual for necessary medical services. See Section 6000.

K. Balance is remaining deductible. From this balance, subtract either:

1. If gross income is in excess of the Categorical Income limit (Chart IVa) and less than the Medicaid rate subtract the MEDICAID RATE for the 6 month period.

2. If gross income is equal to or over the Medicaid rate for the facility but less than the private rate, subtract the PRIVATE RATE for the 6 month period.

III. To determine the cost of care:

A. Determine the gross income for the individual.

B. An adjustment may be made if there are current federal, state or local income tax deductions from the institutionalized spouse's gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed. For example, last year $600 was due in income taxes. $80 per month is withheld for income tax. Only $50 per month can be allowed as a deduction.

NOTE: If an institutionalized spouse is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

C. Subtract the appropriate personal needs allowance. This is

1. $40 per month, or

2. $130 for individuals receiving the reduced VA pension of $90 and for individuals in VA nursing facilities who receive a VA pension and are single with no dependents, or, they are the surviving spouse with no dependents, or

3. up to the maximum dependent allowance (Chart IVb) for an individual who participates in a sheltered workshop. To determine the actual amount:

i. Subtract $40 from unearned income.

ii. Subtract any remainder of the $40 from earned income.

iii. Subtract $50 from any remaining earnings.

iv. Subtract one-half (1/2) of any remaining earnings.

4520 cont.

The deduction of $40 and $50 and the one-half remainder figure are added together. This figure is the personal needs allowance. This figure may not exceed the maximum dependent allowance (Chart IVb).

D. Subtract the cost of

(1) Medicare payments of the individual.

(2) Health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in a Cost Reimbursed Boarding Home or Nursing Facility or covered by a Home Based Waiver.

* Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

NOTE: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

(3) Certain Medical Expenses:

(a) Paid or unpaid medical expenses incurred by a Medicaid covered individual, while residing in the facility, for necessary medical services as long as:

(i) the service is not covered in the per diem rate of the facility, (See Appendix 4-3).

(ii) the service is not one the facility is expected to provide. The facility is expected to provide services contained in a written order or plan of care established by the individual's physician.

(b) Unpaid medical expenses incurred by the individual for necessary medical services. This includes payments on the unpaid balance of a loan taken out to pay for medical expenses incurred prior to Medicaid coverage provided (a) the proceeds of the loan were used to pay the medical bill. Only the amount of the loan actually used to pay the medical bill may be deducted and (b) only the principal (and not the interest) part of the unpaid balance may be used as a deduction.

4520 cont.

(c) A medical expense will not be deducted from the cost of care if:

(i) the expense was covered by insurance (including Medicare)

(ii) the expense was not covered due to a Medicaid penalty period of ineligibility

(iii) the Department has determined that the expense was not the responsibility of the individual because a medical assessment was not timely requested by the facility or because the facility did not timely and adequately assist the individual with filing a Medicaid application. This determination is made by the Bureau of Elder and Adult Services.

(iv) the expense is the unpaid cost of care to a medical institution or a Waiver agency during periods of Medicaid coverage.

(v) the expense was for a Medicaid covered service and the individual was covered by Medicaid.

E. Subtract any spouse's and/or dependent's allocation. These figures are determined in Sections 4220 and 4230.

This is the cost of care if the individual's gross income is over the categorical limit but under the Medicaid rate.

If the individual's gross income is over the Categorical limit but under the Medicaid rate.

Determine the Medicaid rates for the facility for twenty-eight, thirty and thirty-one day months. Compare the countable income to the Medicaid rates determined above. The cost of care is the Medicaid rate or countable income, whichever is less.

Notification of all three cost of care figures are to be provided to the individual each time there is a change in the countable income or Medicaid rate.

EXAMPLE:

Dick Reel entered a nursing facility on 1/17/92, from home. His wife Virginia continues to live in their home. Dick receives $972.00 in Civil Services benefits, $798.00 in Social Security benefits and a pension of $800.00 monthly. Virginia receives $228.80 in Social Security benefits and $176.41 interest income based on 5.5% rate of return on the assets. They have a mortgage of $738.00, taxes of $2592.00, insurance of $73.95 and electric heat. The private rate is $90.00 per day and the Medicaid rate is $65.00 per day.

These figures are based on amounts effective 1/1/92:

INCOME

Virginia's income		Dick's income	
$228.80	Social Security	$ 972.00	Civil Service
176.41	Interest income	978.00	Social Security
$405.21	Total	$2570.80	Total

DEDUCTIBLE

$ 2,570.80	Dick's gross income
- 20.00	Federal disregard
$ 2,550.80	
- 315.00	PIL (1)
$ 2,235.80	
X 6	Deductible period
$13,414.80	Deductible
- 190.80	Medicare premiums
$13,224.00	
- 441.00	Medical insurance premiums
$12,783.00	
-16,200.00	Private rate for 6 months
0.00	Remaining deductible

INCOME ALLOCATION

$1301.17	Shelter expenses
- 296.00	30% of $985
$1005.17	
+ 985.00	Minimum income standard
$1990.17	$1718
$1718.00	Maximum monthly income allowance
- 405.21	Virginia's income
$1312.79	Income allocation to community spouse

4520 cont.

COST OF CARE

$2570.80	Dick's gross income
- 40.00	Personal needs
$2530.80	
- 31.80	Medicare premium
$2499.00	
- 73.50	Medical insurance premium
$2425.50	
-1312.79	Income allocation to community spouse
$1112.71	Cost of care

4520.01 MEDICALLY NEEDY DUE TO GROSS INCOME EQUAL TO OR IN EXCESS OF THE PRIVATE RATE

Follow Section 4520 (II) (A-I) using the private rate in the nursing facility toward meeting the deductible.

If the deductible is met, the individual is eligible for medically needy coverage - no nursing care costs are covered.

If there is a remaining deductible after following Section 4520 (II) (A-I), the deductible is refigured when allowable medical expenses are provided as in Section 4520 (II) (J).

EXAMPLE

Bart Simpson entered a nursing facility on 10/2/87 and is paying privately. His only asset is a noninterest bearing checking account with a balance of $687.04. He applies for Medicaid on 3/16. His total income is $2,697.00 per month. The private rate is $84.00 per day.

These figures are based on amounts effective 1/1/92.

DEDUCTIBLE

$ 2,697.00	Gross income
- 20.00	Federal disregard
$ 2,677.00	
- 315.00	PIL (1)
$ 2,362.00	
X 6	Deductible period
$14,172.00	Deductible
-15,120.00	Private rate
$0.00	Remaining deductible (eligible for Medicaid only effective 3/1. No nursing care services are covered.)

4530 CHANGES IN THE COST OF CARE

1. The individual paid a cost of care that was more than what was actually due. When this was due to Department error, the individual cost of care is adjusted retroactively up to 1 year from the date the error is discovered by the Department. When this was due to error by the individual, no adjustment is made.

2. The individual paid a cost of care that was less than what was actually due.

   Whether this is due to error by the Department or the individual, the individual's cost of care is adjusted retroactively up to (3) months from the date the error is discovered by the Department without advance notice. This includes an adjustment for a lump sum payment (Section 4520.02).

4530.01 NON-COVERED MEDICAL EXPENSES

Verified medical expenses that can be deducted from the cost of care are deducted for the month following the month the bills are received in the office.

EXAMPLE

Jack Snow purchases 2 bottles of Tylenol at $1.49 each and 2 hearing aide batteries at $5.00 each. Receipts are submitted on 3/5/00. Gross Social Security is $591.80.

COST OF CARE FOR APRIL

$591.80	Gross Social Security
- 40.00	Personal needs
- 31.80	Medicare premium
- 10.00	Uncovered medical expenses (see note)
$510.00	Cost of care

NOTE: Cannot allow Tylenol - (should be furnished by facility).

For individuals who die and had incurred non-covered medical expenses, the expenses are not deducted from the cost of care. Individuals who only receive $40.00 per month SSI and have a $0 cost of care are not reimbursed for non-covered medical expenses.

4530.02LUMP SUMS

All lump sum payments are treated as income in the month received. With the exception of Social Security and SSI payments, any portion of retroactive payments remaining the following month is an asset. Social Security and SSI retroactive payments are an excluded asset for six months.

When an eligible client receives a lump sum payment which results in total countable income exceeding the Medicaid rate for a past eligible month, the client's cost of care for that past month is adjusted to the Medicaid rate. This adjustment can be made only if the lump sum was received up to three (3) months prior to the date the error is discovered by the Department.

EXAMPLE:

Judy Bills has been in a nursing facility for six months and on Medicaid. She has a pension of $1,200 per month. The cost of care was $1,160.

The responsible party reports on the 4th of June that Judy received a Social Security check for $3,170 in April.

The Social Security office verifies that the check included retroactive benefits of $2936 and regular monthly benefits of $234.

The countable income for April was $4,370 ($1,200 in pension and $3,170 from social security). The Medicaid rate was $1,800. The cost of care is changed to $1,800 since countable income for April exceeded the Medicaid rate.

$1,800	cost of care for April
-1,434	in regular monthly income
$ 366	needs to be paid from retro benefits

$2,936	total retro benefit
- 366	toward cost of care for April
$2,570	remaining retro for May

For May through October (6 months), the $2,570 remaining retroactive benefits are excluded as a resource.

The cost of care for May and June are refigured based on the pension and monthly social security benefits.